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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Feb/09/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: additional physical therapy 3 x week for 2 weeks thoracic spine, right shoulder, right knee

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of the reviewer that the request for additional physical therapy 3 x week for 2 weeks thoracic spine, right shoulder, right knee is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. The patient reports that her right foot slipped into a crack in the ground. Her right knee twisted and popped and she fell onto her right arm and shoulder, twisting her back. Physical therapy evaluation dated 10/13/14 indicates anterior drawer and compression tests are negative. Impingement, McMurray, supraspinatus and valgus stress are positive. Knee range of motion is -5 to 72 degrees. Physical examination on 11/17/14 indicates that right shoulder range of motion is flexion 108, abduction 52, IR 50 and ER 45 degrees. Right knee range of motion is -4 to 115 degrees. Physical therapy daily note dated 12/01/14 indicates that the patient has completed 16 physical therapy visits to date. The patient states she has 6/10 pain in the right shoulder and 7/10 pain in the right knee. Her back continues to bother her especially with twisting motions. Follow up note dated 01/22/15 indicates that pain levels are unchanged. The patient reports that overall shoulder, thoracic spine and right knee symptoms have remained the same. Range of motion has remained the same. On physical examination anterior and posterior tenderness of the right shoulder has remained the same. Thoracic exam is the same. Right knee range of motion is the same. Strength is the same. Diagnoses are right sprain of neck, right AC joint sprain, right sprain of thoracic and right sprain of knee and leg. Current medications are Naprosyn and Flexeril.

The initial request for additional physical therapy 3 x week x 2 weeks was non-certified on 12/01/14 noting that the patient has attended an unspecified number of supervised PT sessions to help treat pains in her back and right shoulder and right knee and she has been educated in use of a home exercise program. There is little reported objectively measured progress and the progress that has been measured has been incremental improvement in most areas but some regression in some areas, and it is unclear what benefit would be reasonably expected from additional exercises supervised by a therapist than her use of the exercises

independently. The denial was upheld on appeal dated 01/09/15 noting that the claimant has previously completed 118 sessions of physical therapy without documentation of significant reduction in pain or functional gains. She has well-exceeded ODG limitations of the number of allowable sessions of physical therapy for her documented thoracic spine, right shoulder and right knee. It is not likely that an additional 6 sessions is going to have a dramatic impact on her quality of life when 118 sessions of physical therapy has yet to make significant improvement in pain and functional gains.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained sprain/strain injuries to the thoracic spine, right shoulder and right knee and has completed at least 16 physical therapy visits to date. The Official Disability Guidelines support up to 12 sessions of physical therapy for the patient's diagnoses, and there is no clear rationale provided to support exceeding these recommendations. There are no exceptional factors of delayed recovery documented. The submitted records fail to establish that the patient has improved significantly with physical therapy completed to date in order to establish efficacy of treatment and support additional physical therapy in excess of ODG recommendations. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program. As such, it is the opinion of the reviewer that the request for additional physical therapy 3 x week for 2 weeks thoracic spine, right shoulder, right knee is not recommended as medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)